California's Commission on Health and Safety and Workers' Compensation 1997 report concludes that, ''Especially in industries with high premium rates, the illegally uninsured employer is able to underbid the insured employer. Insured employers are again disadvantaged when taxes are raised to cover costs shifted to government services to assist the injured workers of employers who are illegally uninsured.''

Several other states, including Wisconsin and Colorado, are also using proactive programs to identify uninsured employers using computerized lists of employers and workers' compensation politics. In New York, a 1997 audit by the state comptroller's office revealed that employers owe more than $500 million in overdue unpaid workers' compensation insurance premiums to the State Insurance Fund. Failure to secure workers' compensation insurance is only a misdemeanor offense in New York. In West Virginia, the state has been forced to initiate a series of lawsuits to force payment of more than $100 million in unpaid workers' compensation premiums.

Medical Provider Fraud

Workers' compensation fraud also occurs among medical providers. These forms of fraud evolve as the nature of medical care changes over time. Outright fraud occurs when providers bill for treatments that never occurred or were blatantly unnecessary. Some of the newer forms of medical provider fraud include kickbacks from specialists and other treatment providers to referring physicians, and provider upcoding, where provider charges exceed the scheduled amount. Providers also shift from the less expensive, all-inclusive patient report to supplemental reports, which add evaluations and incur separate charges.

Medical provider schemes include: creative billing—billing for services not performed; self-referrals—medical providers who inappropriately refer a patient to a clinic or laboratory in which the provider has an interest; upcoding—billing for a more expensive treatment than the one performed; unbundling—performing a single service but billing it as a series of separate procedures; product switching—a pharmacy or other provider bills for one type of product but dispenses a cheaper version, such as a generic drug.

Newer forms of fraud and abuse occurring under managed care arrangements include: underutilization—doctors receiving a fixed fee per patient may not provide a sufficient level of treatment; overutilization—unnecessary treatments or tests given to justify higher patient fees in a new contract year; kickbacks—incentives for patient referrals; internal fraud—providers collude with the medical plan or insurance company to defraud the employer through a number of schemes.

According to the National Council on Compensation, ''The increased use of managed care for workers' compensation, as well as for other insurance lines, is bringing new twists to old schemes,'' Managed care creates more opportunities for fraud because of the financial relationships and incentives between players.

Although the campaign against California medical mills wiped out a substantial part of medical provider abuse in that state, new cases continue to emerge. In October of 1997, for example, a pharmacist plead guilty to 21 counts of fraudulent workers' compensation insurance billing. The pharmacist increased his revenues by up to 500% per prescription on more than $600,000 of drugs sold over a four year period.

Insult Added to Injury

Because of the assumption of widespread claimant fraud, injured workers who file a workers' compensation claim may be subjected to insulting questions and treated as malingerers and cheats. Under the auspices of ''fraud prevention,'' they may face endless questioning and unnecessary medical examinations. They may be subjected to constant video surveillance by private investors hired to follow their every move. Their employer may refuse to provide light duty work, or take retaliatory actions against them when they return to work. If they look for another job, their application may be screened for prior workers' compensation claims.

Although some of these tactics are used in legitimate attempts to investigate questionable claims, they have also become part of a broad employer attempt to intimidate workers from filing workers' compensation claims. Under the pretext of controlling what has been falsely presented as rampant claimant fraud, injured workers are discouraged form exercising their legitimate rights to workers' compensation benefits. As a recent Michigan study demonstrated, the real problem in workers' compensation is not that too many workers claim benefits, but that too few do so. The study, sponsored by the National Institute for Safety and Health, found that only one in four workers with occupational diseases file for workers' compensation. Unsubstantiated charges of rampant claimant fraud undermine public confidence in the system and discourage legitimately injured workers from seeking the benefits they need and deserve.

In California, a detailed investigation by state auditors found that ''workers' compensation insurers violated workers' rights in about half the claims it audited.'' The violations included ''unacceptably high amounts'' of unpaid benefits, late payments, inaccurate benefit notices and failure to notify injured workers of their rights. In describing the experience of many workers' compensation claimants. The Santa Rosa Press Democrat found that many injured workers slam into a wall of suspicion and distrust that will paralyze them with shame and frustration and delay their recovery. One of the injured workers interviewed by the newspaper commented: ''You get the feeling that even though you have a legitimate complaint and a six-inch scar, you're somehow a malingerer.''

The grossly overstated estimates of claimant fraud have not only subjected injured workers with legitimate claims to fear and intimidation, but have also obscured a more serious look at the workers' compensation system and the benefits it provides. The real question is not why there is so much claimant fraud, but why there is so little. In most states, workers' compensation benefits provide little more than poverty-level existence. Workers often wait weeks and months for payments.

Many employers refuse to provide light duty or alternative jobs for workers who might be able to go back to work in a modified capacity while they continue to recover, so workers are forced to continue on inadequate benefit payments even though they may be able to work in some capacity. Some injured workers lose their jobs or are only offered positions at much lower pay. It is little wonder that so many claimant fraud cases involve workers illegally continuing to accept benefits when they are in fact working at another establishment. Too many times, inadequate benefits put people in desperate straits, and they take desperate measures as a result. A system that leaves people in poverty invites abuse.

The presumption of widespread malingering and dishonesty undercuts any meaningful discussion of the adequacy of benefits and provides a convenient response for those opposed to the benefit increases that are so critically needed in many states. Until the misplaced focus on claimant fraud is overcome, district attorneys will continue to fry the small fish while the big fish go free, and the voting public will remain distracted by anecdotes.

PERSONAL EXPLANATION

HON. DANNY K. DAVIS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, October 9, 1998

Mr. DAVIS of Illinois. Mr. Speaker, on September 17, 1998, I was unavoidably detained from casting my vote on Roll Call number 448. However, if I had been present, I would have voted ''aye'' on this amendment.

PRESCRIPTION DRUG PRICING

HON. MARION BERRY

OF ARKANSAS

IN THE HOUSE OF REPRESENTATIVES

Friday, October 9, 1998

Mr. BERRY. Mr. Speaker, I rise today to announce the formation of the Prescription Drug Task Force.

I have enjoyed working with Representatives ALLEN and TURNER to form the task force.

The task force will work to bring attention to issues involving the costs and availability of prescription drugs.

The task force will serve as a clearinghouse for information on these issues and will host educational forums, briefings, and hearings.

One of the things we will focus on is continuing to hold forums like the one we hosted last week, where members will be given an opportunity to participate in discussions and learn how consumers are being affected by the pricing decisions of pharmaceutical companies.

One thing I would like to talk about tonight is how the most profitable industry in existence (that is legal) and why that industry's practice of making excessive profits from the elderly and uninsured Americans is bad news.

According to industry ratings of Fortune 500 companies—pharmaceutical companies are the most profitable businesses in existence. They made $24.5 billion in profits last year. Pharmaceutical companies had a 17.2 percent return on revenues. That compares to telecommunication companies who had an 8.1 percent, computers and office equipment manufacturers who had 7.3 percent, food and drug stores that made 1.7 percent.

One might think the successful pharmaceutical companies would be of tremendous benefit to American consumers. This couldn't be more wrong.

And unfortunately, while the pharmaceutical companies are making tremendous profits, the American people are being gouged. Thousands of consumers, especially seniors, have found themselves affected by the price of prescription drugs in this country.

Studies that have been conducted by the minority staff of the Government Reform and Oversight Committee for several Members of Congress, including myself, over the last several months. These studies have shown the prices seniors and other consumers are